Appendix 14
Wisconsin Medicaid Declaration of Supervision and Authorization to Pay Agreement for Non-Billing Providers

The following providers are issued non-billing provider numbers (*cannot be used independently* to bill Wisconsin Medicaid), must be under professional supervision to be Medicaid-certified providers and *must* complete this form:

Alcohol and Other Drug Abuse Counselor (31/048)
Psychiatric Nurse (31/049)
Master's Level Psychotherapist (31/078)
Physical Therapy Assistant (34/077)
Occupational Therapy Assistant (35/114)
Speech Pathologist, BA Level (78/091)
Physician Assistant (88/079)

Return to: EDS, Attn: Provider Maintenance, 6406 Bridge Road, Madison, WI 53784-0006

To be completed by the applicant who is a Non-Billing Provider or Current Non-Billing Provider who has a Change in Work Address or Supervisor (always required):

Name and Credentials:_____ Phone:(_____)_____

WorkMailingAddress:_____

Since Wisconsin Medicaid payments cannot be made payable to me, I, _____, hereby direct the fiscal agent for Wisconsin Medicaid, EDS, to make checks payable to (clinic or supervisor's name for providers other than mental health) _____ for all claims payments for services performed by me under Wisconsin Medicaid. I understand that this payment arrangement shall continue in effect until the fiscal agent receives a new Declaration of Supervision form from me. When my supervisor, employer or work address changes, I will immediately send this form completed again to the fiscal agent.

_____ _____ _____
Date Signature of Non-Billing Provider Wisconsin Medicaid Provider Number

To be completed by the Supervisor (always required):

Name:_____ Employer IRS #_____ Phone:(_____)_____

Address:_____

I, _____, am supervising the work of _____.
The effective starting date of my supervision was _____. I hereby acknowledge and agree to the above payment arrangement. I understand that if my name is indicated in the above section, Wisconsin Medicaid checks for services provided by the above provider will be payable to me directly and will be reported under the IRS# written here. If I discontinue supervision of the above, I understand that I must send notice to the fiscal agent at the above address.

_____ _____ _____
Date Signature of Supervisor Wisconsin Medicaid Provider Number

To be completed by the Clinic Manager (required for mental health non-billers only):

NOTE: Outpatient mental health/AODA clinics who employ non-billing providers *must* be certified by the Division of Community Services *and* Wisconsin Medicaid. Staff of non-51.42 board clinics providing Wisconsin Medicaid services *must* be individually certified.

On behalf of (Clinic Name) _____, (Wisconsin Medicaid Provider Number) _____, I hereby acknowledge and agree to the above payment arrangement. I understand that Wisconsin Medicaid checks for services provided by the above non-billing provider will be payable to the clinic and reported under this IRS#.

_____ _____ _____
Date Name and Signature of Clinic Manager Employer IRS #

Clinic Address:_____ Phone:(_____)_____